think they are benefiting our patients and us as well. But, as in earlier times when the clergy burned people at the stake to save their souls, their medicine is killing the patient: paper work inundates us, malpractice suits assail us, and cost-effectiveness experts castigate us. Faced with increasing regulations, mounting insurance premiums, rising public criticism and moves toward socialization, physicians are leaving this profession, and bright students are entering others.

What can we do to staunch this loss of our life's blood? Our main defense lies in our patients. When they are pleased with our performance we are less vulnerable. Unfortunately, one problem we face is the patient's notion that doctors are omniscient and omnipotent, a harmfully erroneous attitude. As one lawyer remarked, "Patients think of doctors as junior gods, but since people don't understand God, they don't understand doctors either." Let us help our patient-employers understand us better. To do this we must descend from the pedestal they have placed us on. We must let them know our humanity, our shared concerns, what we can and cannot do.

We can also publicize the virtues of our profession. Medicine is both *logical* and *moral*. Unlike the legal profession, which is logical and amoral (legalizing tobacco) and the clerical profession, which is moral but illogical (opposing all abortion, all euthanasia), the medical profession stands as a corrective, judicious balance between law's critical, analytical left-hemisphere mode and religion's emotional, intuitive right-hemisphere mode. Whereas both left-mode and right-mode strive for *perfection* (the enemy of good), the balanced mid-mode, by adhering to a standard and allocating functions to whichever hemisphere does it best, strives toward *good*. (Interestingly, the judiciary, the clergy and the villainous Darth Vader wear black; the medical profession, the nursing profession and the heroic Luke Skywalker wear white.) Medicine's role, then, is to care for the real physical and psychological needs of mankind. We are neither paid to marshal arguments for legislation in this life or prepare souls for the next. We are simply concerned with what is knowably true and good. I suggest that we need to communicate this more clearly.

So we must learn to speak and write more persuasively. To this end, including a Dale Carnegie type course in public speaking and effective communication[3,4] in the medical school curriculum, and for practitioners as well, might help us compete with lawyers and clergymen who are trained in persuasion. *We must develop all the tools necessary to protect our position as the guardians of people's health.* By balancing art and science, morality and logic, humanism and research, we can not only benefit our patients, but also help preserve the life of the medical profession our ancestors fought so valiantly to revive and bequeath to us.

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REFERENCES

1. Edwards B: Drawing on the Right Side of the Brain. Los Angeles, JP Tarcher Inc, 26-40, 1979
2. Major RH: A History of Medicine. Springfield, IL, Charles C Thomas, 207-478, 1954
3. Carnegie D: The Quick and Easy Way to Effective Speaking. Garden City, Dale Carnegie & Associates, Inc, 1962
4. Carnegie D: How to Win Friends and Influence People. New York, Simon and Schuster, 1964

High Altitude Flatus Expulsion (HAFE)

TO THE EDITOR: We would like to report our observations upon a new gastrointestinal syndrome, which we shall refer to by the acronym HAFE (high altitude flatus expulsion). This phenomenon was most recently witnessed by us during an expedition in the San Juan Mountains of southwestern Colorado, with similar experiences during excursions past. The syndrome is strictly associated with ascent, and is characterized by an increase in both the volume and the frequency of the passage of flatus, which spontaneously occurs while climbing to altitudes of 11,000 feet or greater. The eructations (known to veteran back-packers as "Rocky Mountain barking spiders") do not appear to vary with exercise, but may well be closely linked to diet.[1] The fact that the syndrome invariably abated on descent leads us to postulate a mechanism whereby the victim is afflicted by the expansion of colonic gas at the decreased atmospheric pressure of high altitude. This is somewhat analogous to the rapid intravascular expansion of nitrogen which afflicts deep-sea divers and triggers decompression illness.

While not as catastrophic as barotrauma nor as debilitating as HAPE (high altitude pulmonary edema), HAFE nonetheless represents a significant inconvenience to those who prefer to hike in company. Some experience from recent Everest expeditions suggests that the use of digestive enzymes and simethicone may minimize the hazard.

At present, we can advise victims that the offense is more sociologic than physiologic.

HAFE should be added to the growing list of medical disorders that are associated with exposure to high altitude. We are planning a prospective study for the summer of 1981.

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REFERENCE

1. Levitt MD, Lasser RB, Schwartz JS, et al: Studies of a flatulent patient. N Engl J Med 295:260-262, Jul 29, 1976

Medicaid and the Medical Profession

TO THE EDITOR: It would be unfortunate for the medical profession to view Medicaid as a "dismal failure" (Meyerowitz BR: Medi-Cal: A Debacle? West J Med 133:449-450, Nov 1980). When Congress enacted Medicare in 1965, it tacked on the American Medical Association's Eldercare proposal but spelled out its benefits to those who were "medically indigent" and called it Medicaid. This was the *sleeper clause* that some saw as the real troublemaker for the country and medical profession because of the experience with the Kerr-Mills program (*Chicago Tribune,* August 20, 1966). The same basic premise, medical indigence, underlay the old Kerr-Mills program which applied only to the aged. This program was actively and passively opposed by those who disliked its means test (calling it a "pauper's oath," which it decidedly was not) and who were committed to the all or none principle of coverage for benefits. Various obstacles were used to prevent its smooth operation where enacted and in many states even its initiation was blocked. The same ideologic forces, intent upon a total federal program, are lined up against Medicaid.

In 1965 there were those who actually believed that those concrete forests of old-fashioned public *charity,* the municipal hospitals, would close their doors "because Medicare and Medicaid should do away with the need for hospitals that take care of the indigent." Dr. Meyerowitz and the rest of us know better today. We have not forgotten the promises that physicians would not have to donate their services to charitable purposes; we recognize them as the usual inducements to encourage less opposition to proposed legislative medical measures.

The derogatory portrayal of Medicaid ought to act as a catalyst to a dogged perseverance in our attack on the opposition through repeated emphasis on the benefits of Medicaid. It would seem proper to emphasize that Medicaid has had an effect for the better on the delivery of health services to the poor. Some improvements are necessary, but let us not dump the program and join the opposition. Some progress towards a one-class system of medical care was made in the 15 years of existence of Medicaid. But the zeal for such a result should be tempered by the recognition that even in England the effort is failing significantly.

There is some recent indication of encouragement with the use of computerized management systems in Medicaid administration. Furthermore, suggestions to increase Medicaid reimbursement and reduce payment delays would aid "to integrate the poor into mainstream medicine" (*American Medical News,* December 5, 1980).

The criticism that most of Medicaid expenditures go to the elderly and disabled (Medicare beneficiaries) substantiates the error of the Medicare program, which provides a little for the many (even those without the need for such subsidy) rather than enough or much for the few who really need it. Such recognition should provide the AMA with its Eldercare proposal grounds for the statement "I told you so."

And the lesson for us in the private sector? Above all, it is to continue to adhere to ethical and moral codes in our care of all patients. And we must not utilize the tactic of the opposition (the constant widespread repetition of exaggerations, half-truths and half-lies) but rather provide factual information and calm diligent disclosure of errors and misunderstandings, and of fraud and abuse. Such a program could have a constructive impact on public opinion and reinforce the current effort of those intent upon diminishing the overextended role of government in medical care provision.

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